

EXHIBIT B

Social Security Number

El Numero de su Seguro Social

1 1 2 6 4 3 2 6 4

IMPORTANT:

Your Social Security Number Must Be Entered

IMPORTANTE:

El Numero de su Seguro Social Debe Ser Indicado

INDEX

WCB Case No. (If Known)

Carrier Case No. (If Known)

ANSWER ALL QUESTIONS FULLY

Injured Person

1. Name Roni Giladi
First Name Middle Name Family Name
2. Address P.O. Box 127 Millburn New Jersey 07041
Number and Street (Include Apt. No.) City State Zip Code
3. Sex M Age 41 Date of Birth 03/05/52 Married or single Married
4. Do you speak English? Yes If not, what language do you speak?
5. Name of union and local number, if member 1199 National Benefit Fund
6. State what your regular work was Video Production
7. What were you doing when you were injured? Loading the car with video equipment.
8. Wages or average earnings per day, including overtime, board, rent and other allowances \$
9. Were you paid full wages for the day of injury?

XX	Yes		No
----	-----	--	----
10. Were you at the time of injury a piece worker?

	Yes	XX	No
--	-----	----	----

Or a time worker?

XX	Yes		No
----	-----	--	----
11. Your work week, at time of injury was (check one)

XX	5 day		6 day		7 day
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Other

Employer

1. Employer Albert Einstein College of Medicine Telephone No. (718) 430-2135
2. Employer's address 1300 Morris Park Avenue, Bronx New York 10461
Number and Street City State Zip Code
3. Name of Supervisor Richard DeWitt
4. Nature of employer's business Audio Visual

Place and Time

1. Address and county where injury occurred 1300 Morris Park Avenue, Bronx New York.
3. Date of injury June 30, 1993 at App. 4:00 o'clock P. M.
Month Day Year

The Injury

1. How did injury occur? At the time I was trying to load the videocamera into the trunk of the car, the unit was so heavy, it hurt my hand and as a result, I lost balans. As I tried to regain my balans, I hurt my back & hand.

Nature and Extent of Injury

1. State fully nature of your injury/illness Back pain spread to the legs, pain in both hands and swollen of left hand.
2. On what date did you stop work because of this injury? August 10, 1993, 19
3. Have you returned to work? No If "Yes" on what date _____, 19
(Yes or No)
4. Does injury keep you from work?

XX	Yes		No
----	-----	--	----
5. Have you done any work during period of disability? No
6. Have you received any wages since your injury? Yes If "Yes" for what period? July 1, 1993 until August 9, 1993
and at what rate? _____ (check one)

	Hourly		Daily	XX	Weekly
--	--------	--	-------	----	--------
7. Has injury resulted in amputation? _____ If so, describe same _____

Medical Benefits

1. Did you receive medical care?

XX	Yes		No
----	-----	--	----
2. Are you now receiving medical care?

XX	Yes		No
----	-----	--	----
3. Are you now in need of medical care?

XX	Yes		No
----	-----	--	----
4. Have you requested your employer to authorize medical care?

	Yes		No
--	-----	--	----
5. Name and address of attending doctor Coralia L. Popescu., M.D. 1600 Penbroeck Ave. Bronx N.Y.
6. If you were in a hospital, give the dates hospitalized _____
Name and address of hospital _____

Workers' Compensation Payments

1. Have you received workers' compensation payments for the injury reported above?

	Yes	XX	No
--	-----	----	----
2. Are you receiving workers' compensation payments?

	Yes	XX	No
--	-----	----	----
3. Do you claim further workers' compensation payments?

XX	Yes		No
----	-----	--	----

If "Yes" explain I have not received any workers' compensation payments as of yet; I should receive the payments for the loss of work due to my job injury.

Notice

1. Have you given your employer (or supervisor) notice of injury?

XX	Yes		No
----	-----	--	----

If "Yes" such notice was given to (Name) Richard DeWitt on July 1, 1993, 19
2. Was notice given orally or in writing? Orally on 7/1/93, followed by written notice few weeks later.

I hereby present my claim to the Chair, Workers' Compensation Board, for compensation for disability resulting from an accidental injury or occupational disease arising out of and in the course of my employment and not occasioned by my willful intention or solely through intoxication, and in support of it I make the foregoing statement of facts.

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY FILES A STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME.

Dated August 25, 1993Signed by Roni Giladi

Claimant

Mail Address P.O. Box 127

Telephone No. _____

Millburn, New Jersey 07041
City State Zip Code Apt. No.

(SEE OTHER SIDE FOR IMPORTANT INFORMATION) — (VEASE AL DORSO PARA INFORMACION DE IMPORTANCIA)

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C-3

C-3

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C-3

(10-90)

THE WORKERS' COMPENSATION BOARD EMPLOYS AND SERVES PEOPLE WITH DISABILITIES WITHOUT DISCRIMINATION.
 LA JUNTA DE COMPENSACION OBRERA EMPLEA Y SIRVE A PERSONAS INCAPACITADAS SIN DISTINCION.

006177

WORKERS' COMPENSATION BOARD
EMPLOYER'S REPORT OF INJURY/ILLNESS

Send this notice directly to Chairman, Workers' Compensation Board at address shown on reverse side within ten (10) days after accident occurs. Answer all questions fully. Copy also should be sent to your insurance carrier. This form replaces all previous versions of Forms C-2 and C-2.5.

PLEASE PRINT OR TYPE—INCLUDE ZIP CODE IN ALL ADDRESSES—EMPLOYEE'S S.S. NO. MUST BE ENTERED BELOW

WCB CASE NO. (If Known)	CARRIER CASE NO.	CODE NO.	WC POLICY NUMBER	DATE OF ACCIDENT	EMPLOYEE'S S.S. NO.
09345579		W204002	929-969-4	12/18/91	112-64-3264
1.(a) EMPLOYER'S NAME Yeshiva University		(b) EMPLOYER'S MAILING ADDRESS 1300 Morris Pk Ave Bx 10461		(c) OSHA CASE/FILE NO.	
(d) LOCATION (If different from mail address)		(e) NATURE OF BUSINESS (Principal products, services, etc.) School		(f) NYS U.I. Employer Reg. No.	
2. (a) INSURANCE CARRIER THE STATE INSURANCE FUND			(b) CARRIER'S ADDRESS 199 Church Street, New York, NY 10007		
3. (a) INJURED PERSON (FIRST, M.I., LAST) Roni Melodi			(b) ADDRESS (Include No. & Street, City, State, Zip & Apt. No.) P.O. Box 127 Millburn NJ 07041		
ACCIDENT	4. ADDRESS WHERE ACCIDENT OCCURRED Nurses Residence		5. TIME OF ACCIDENT AM PM	6. DEPT. WHERE REGULARLY EMPLOYED Audio Visual	7. (a) DATE STOPPED WORK BECAUSE OF THIS INJURY/ILLNESS 12/19/91
	8. SEX M		9. AGE 39	10. OCCUPATION (Specific job title at which employed) Video Technician	11. (a) AVERAGE EARNINGS PER WEEK 697.55
INJURED PERSON	12. (a) PART OR FULL TIME WORKER? FT		(b) INJURED WORKER'S WORK WEEK (Indicate days of week usually worked). M-F		(b) WAS INJURED PAID IN FULL FOR DAY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
	13. NATURE OF INJURY AND PART(S) OF BODY AFFECTED Injured left hand		14. DID YOU PROVIDE MEDICAL CARE? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		IF YES, WHEN? 12/19/91
NATURE OF INJURY	15. (a) NAME AND ADDRESS OF DOCTOR		(b) NAME AND ADDRESS OF HOSPITAL		
	16. HAS EMPLOYEE RETURNED TO WORK? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		IF YES, DATE 12/23/91		AT WHAT WEEKLY WAGE?

NOTE: FORM C-11 MUST BE FILED EACH TIME THERE IS A CHANGE IN EMPLOYMENT STATUS

CAUSE OF ACCIDENT	17. WHAT WAS EMPLOYEE DOING WHEN INJURED? (Please be specific. Identify tools, equipment or material the employee was using.) Carrying cart containing video equipment down stair injured left hand while lifting cart. Employee had surgery on 12/12/91 on left hand.		
	18. HOW DID THE ACCIDENT OR EXPOSURE OCCUR? (Please describe fully the events that resulted in injury or occupational disease. Tell what happened and how it happened. Please use separate sheet if necessary.) While carrying equipment cart, injured hand that had been operated on on 12/12/91, six days before accident.		
	19. OBJECT OR SUBSTANCE THAT DIRECTLY INJURED EMPLOYEE, e.g., the machine employee struck against or which struck him/her, the vapor or poison inhaled or swallowed, the chemical that irritated his/her skin. In cases of strains, the thing(s) he was lifting, pulling, etc. Cart injured hand that was in cast or brace.		
FATAL CASES	20. DATE OF DEATH	NAME/ADDRESS OF NEAREST RELATIVE	RELATIONSHIP

DATE OF THIS REPORT 12/2/93

SIGNED BY Maura Costello

DATE YOU OR SUPERVISOR FIRST KNEW OF INJURY 11/24/93

OFFICIAL TITLE Benefits Supervisor

CHECK BOX IF PREVIOUSLY REPORTED ON FORM C-2.1.

AREA CODE, TEL. NO. & EXT. (718) 430-3276

THE WORKERS' COMPENSATION BOARD EMPLOYS AND SERVES THE HANDICAPPED WITHOUT DISCRIMINATION.

C-2 (6-86)

C-2

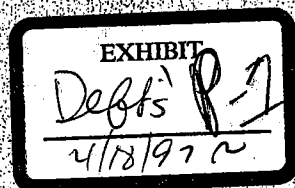
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006175



City Number
Número de su Seguro Social

1112

64

3364

IMPORTANT:

Your Social Security Number Must Be Entered

IMPORTANTE:

El Número de su Seguro Social Debe Ser Indicado

WCB Case No. (If Known)

0935-6779

State of New York
Carrier Case No. (If Known)

38398020-0441

ANSWER ALL QUESTIONS FULLY

Injured
Person

1. Name Roni Gikadi
First Name Middle Name Family Name
2. Address PO Box 127 Hillborn NJ 07041
Number and Street (include Apt. No.) City State Zip Code
3. Sex M Age 31 Date of Birth 5/9/53 Married or single Married
4. Do you speak English? Yes If not, what language do you speak?
5. Name of union and local number, if member UAW
6. State what your regular work was Video Technician
7. What were you doing when you were injured? Repairing
8. Wages or average earnings per day, including overtime, board, rent and other allowances \$ 7.00
9. Were you paid full wages for the day of injury? ☐ Yes ☐ No
10. Were you at the time of injury a piece worker? ☐ Yes ☐ No
Or a time worker? ☐ Yes ☐ No
11. Your work week, at time of injury was (check one) ☒ 5 day ☐ 6 day ☐ 7 day
12. Other _____

Employer

1. Employer Yeshiva University Telephone No. _____
2. Employer's address Albert Einstein
Number and Street City State Zip Code
3. Name of Supervisor 1300 Morris Park Avenue
4. Nature of employer's business Bklyn 10416

Place
and
Time

1. Address and county where injury occurred Same
2. Date of injury 6/30/93, at _____ o'clock _____ M.
Month Day Year

The
Injury

1. How did injury occur? loading a car with video equipment
HA. his left elbow on trunk lid - started to pop
forward - L. shoulder back in hands in trying to

Nature
and
Extent
of
Injury

1. State fully nature of your injury/illness Added on my left shoulder
Back / Both hands
2. On what date did you stop work because of this injury? 8/9/93, 19____
3. Have you returned to work? Yes If "Yes" on what date _____, 19____
(Yes or No) ☐ Yes ☐ No
4. Does injury keep you from work? Yes ☐ Yes ☐ No
5. Have you done any work during period of disability? Yes
6. Have you received any wages since your injury? Yes If "Yes" for what
period? _____ and at what rate? _____ (check one) ☐ Hourly ☐ Daily ☐ Weekly
7. Has injury resulted in amputation? No If so, describe same _____

Medical
Benefits

1. Did you receive medical care? ☒ Yes ☐ No
2. Are you now receiving medical care? ☒ Yes ☐ No
3. Are you now in need of medical care? ☒ Yes ☐ No
4. Have you requested your employer to authorize medical care? ☒ Yes ☐ No
5. Name and address of attending doctor Dr Goldstein & Dr Popescu
6. If you were in a hospital, give the dates hospitalized _____
Name and address of hospital _____

Workers'
Compensation
Payments

1. Have you received workers' compensation payments for the injury reported above? ☐ Yes ☒ No
2. Are you receiving workers' compensation payments? ☐ Yes ☒ No
3. Do you claim further workers' compensation payments? ☒ Yes ☐ No
If "Yes" explain lost time permanent damage

Notice

1. Have you given your employer (or supervisor) notice of injury? ☐ Yes ☒ No
If "Yes" such notice given to (Name) _____ on _____, 19____
2. Was notice given orally or in writing? ☐ Yes ☒ No

I hereby present my claim to the Chairman, Workers' Compensation Board, for compensation for disability resulting from an accidental injury or occupational disease arising out of and in the course of my employment and not occasioned by my willful intention or solely through intoxication, and in support of it I make the foregoing statement of facts.

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY FILES A STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME.

Dated 9/28/93, 19____

Signed by _____

Mail Address _____

PO Box 127 Hillborn
New Jersey
Number and Street City State Zip Code Apt. No.

Telephone No. _____

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C-3

C-3

THE WORKERS' COMPENSATION BOARD EMPLOYS AND SERVES THE HANDICAPPED WITHOUT DISCRIMINATION
LA JUNTA DE COMPENSACION OBRERA EMPLEA Y SIRVE A PERSONAS INCAPACITADAS SIN DISTINCION.

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EXHIBIT

Deft's Q
11/1/07

SI NECESITA QUE LE AYUDEN A LLENAR ESTA FORMA, LLAME POR TELEFONO O ACUDA A LA OFICINA DE DISTRITO MAS CERCANA DE LA JUNTA DE COMPENSACION OBRERA. VEA LAS DIRECCIONES Y LOS NUMEROS DE TELEFONO AL DORSO.

Social Security Number
El Numero de su Seguro Social

112 64 32 64

IMPORTANT: Your Social Security Number Must Be Entered
IMPORTANTE: El Numero de su Seguro Social Debe Ser Indicado
State of New York
Carrier Case No. (If Known)

WCB Case No. (If Known)

ANSWER ALL QUESTIONS FULLY

Injured Person

1. Name Roni Giladi
First Name Middle Name Family Name
2. Address PO Box 127 Hillburn NJ 07031
Number and Street (include Apt. No.) City State Zip Code
3. Sex M Age 31 Date of Birth 5/15/62 Married or single single
4. Do you speak English? yes If not, what language do you speak?
5. Name of union and local number, if member
6. State what your regular work was video technician
7. What were you doing when you were injured? regular work
8. Wages or average earnings per day, including overtime, board, rent and other allowances \$ 300-500
9. Were you paid full wages for the day of injury? Yes No
10. Were you at the time of injury a piece worker? Yes No
Or a time worker?
11. Your work week, at time of injury was (check one) 5 day 6 day 7 day
Other

Employer

1. Employer Albert Einstein College of Medicine Telephone No.
2. Employer's address
3. Name of Supervisor Bob DeLitt Zip Code 07031
4. Nature of employer's business Richard DeLitt

Place and Time

1. Address and county where injury occurred
2. Date of injury 12/18/91, at 9 o'clock PM
Month Day Year

The Injury

1. How did injury occur?
A falling cartage - roller over his left hand

Nature and Extent of Injury

1. State fully nature of your injury/illness
left hand
2. On what date did you stop work because of this injury? 12/18/91, 19
3. Have you returned to work? yes If "Yes" on what date 3/15/92, 19
4. Does injury keep you from work? Yes No
5. Have you done any work during period of disability? yes
6. Have you received any wages since your injury? from work If "Yes" for what period?
and at what rate? (check one) Hourly Daily Weekly
7. Has injury resulted in amputation? no If so, describe same

Medical Benefits

1. Did you receive medical care? Yes No
2. Are you now receiving medical care? Yes No
3. Are you now in need of medical care? Yes No
4. Have you requested your employer to authorize medical care?
5. Name and address of attending doctor Dr. Strauss + Dr. Goldstein
6. If you were in a hospital, give the dates hospitalized
Name and address of hospital

Workers' Compensation Payments

1. Have your received workers' compensation payments for the injury reported above? Yes No
2. Are you receiving workers' compensation payments? Yes No
3. Do you claim further workers' compensation payments? Yes No
If "Yes" explain Permanent Damage

Notice

1. Have you given your employer (or supervisor) notice of injury? Yes No
If "Yes" such notice given to (Name) Richard DeLitt, 19
2. Was notice given orally or in writing? orally 12/18/91

I hereby present my claim to the Chairman, Workers' Compensation Board, for compensation for disability resulting from an accidental injury or occupational disease arising out of and in the course of my employment and not occasioned by my willful intention or solely through intoxication, and in support of it I make the foregoing statement of facts.

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY FILES A STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME.

Dated 5/28/93, 19

Signed by

Mail Address

Telephone No.

City

State

Zip Code

Apt. No.

C-3

C-3

C-3

C-3

C-3

THE WORKERS' COMPENSATION BOARD EMPLOYS AND SERVES THE HANDICAPPED WITHOUT DISCRIMINATION
LA JUNTA DE COMPENSACION OBRERA EMPLEA Y SIRVE A PERSONAS INCAPACITADAS SIN DISTINCION.

EXHIBIT

DeLitts' P-2

SIN OLVIDAR QUE LE AYUDEN A LLENAR ESTA FORMA, LLAME POR TELEFONO O ACUDA A LA OFICINA DE DISTRITO MAS CERCANA DE LA JUNTA DE COMPENSACION OBRERA. VEA LAS DIRECCIONES Y LOS NUMEROS DE TELEFONO AL DORSO.

THE STATE INSURANCE FUND
CLAIMS-MEDICAL DEPARTMENT
REPORT OF FIELD INVESTIGATION

Roni Giladi 12/18/91 Yeshiva University 38846663-044

Claimant Date of Acc. Employer Case No.

2. Assured's current address 1300 Morris Park Avenue, Bronx, NY 10461

3. Person Interviewed: Maura Castillo Title: Benefits Supervisor

4. How long associated with Assured? since 1992 Assured's Telephone No.: 718-430-2560

CLAIMANT'S INFORMATION

5. Social Security No: 112-64-3264 Date of Birth: 3/5/52 Home Phone No: not available

6. Occupation: Radio Technician How long employed: 1/4/82

7. Describe duties: Video tapes surgery, medical procedures, setting up audio-visual materials for meetings and conferences, editing tapes, etc.

8. Wages: 697.5 per hour week Days worked per week: 5 Last day paid: 12/18/91 Last day worked: 12/18/91
☐ day ☐ year was paid (see report)

9. Wages being paid during disability? YES Is reimbursement desired?

10. Notice given to: Richard Dewitt Title: Supervisor Date: 11/24/93

11. Witnesses: Name: Jerri Landi Address: 1300 Morris Park Avenue, Bronx, NY

Name: Address: NO

12. Does assured know of prior conditions/ accidents/operations or medical treatment (Sec 15-8)

13. To whom was second injury law explained? Name: not explained Title:

14. Does assured know if claimant has applied for unemployment insurance or disability benefits? Yes

15. Name and address of disability carrier: National Benefits Life

16. Doctor: Dr. Berish Staruch Address: 3331 Bainsbridge Ave. Bx. NY

17. Hospital: not available Address:

18. Has claimant returned to work? YES If so when? 12/21/91 Same firm? yes Current wages: same

19. Third Party (Name and Address), If none, state "None": None

DESCRIPTION OF ACCIDENT

On 5/6/94 in the (a.m.) (p.m.), I visited by appt. 1300 Morris Park Ave., Bronx, NY
 (Date) (Address)

and interviewed Ms. Maura Castillo, Benefits Supervisor of Yeshiva University

(Name and Title of Interviewee) (Name of Assured)
 who stated that it was for the medical authorities to decide the nature of

the disability of the claimant.

On 12/18/91 at the Nurse's Residence of the Jacoby Hospital
 complex the accident occurred. She was setting up radio

equipment for a conference there. The building belongs to

Signature M.S. Alexander
 (Investigator)

Date: 5/6/94

M.S. Alexander
 Sr. Compensation Claims Investigator

USE OTHER SIDE FOR REMARKS

38846663-044

Giladi

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Yeshiva University, and this was a conference sponsored by the University.

When carrying a cart containing video equipment down the stairs, the claimant injured his left hand while lifting the cart. Mr. Jerri Landi of the Audio-Visual Department was a witness to the accident. The claimant and Mr. Landi were lifting the cart together.

The claimant's left hand was in a cast. He had surgery to the left hand on 12/12/91.

As per the claimant the accident was reported to his Supervisor the same day, but the Supervisor said it was reported to him only on 11/24/93.

The claimant was on sick leave on 12/19/91 and 12/20/91. He returned back to work on 12/21/91 and continued to work until 1/8/92.

Since 1/8/92 through 3/30/92 he was on disability. The doctor's note dated 2/17/92 shows that the diagnosis is compression of the left median nerve of the wrist.

For this period he collected disability from 1199 National Benefits Fund.

Since he returned back to work on 3/30/92, he had no further lost time due to this injury. The doctor's note also indicates that his condition is not job related.

M. S. Alexander

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Giladi
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The assured did not receive any medical notes, but the disability form is signed by Dr. Berish Staruch, 3331 Bainsbridge Avenue, Bronx, New York. The diagnosis is compression of left medial nerve at the wrist.

For the surgery, he was out from 12/12/91 through 12/17/91. He was on sick leave during this period. The informant does not know where the surgery was performed.

The informant does not know the real condition of the hand. It was not job related.

The disability form indicates that the diagnosis was compression of the left medial nerve at the wrist. The doctor doesn't indicate it was job related. On the other hand, he indicates it is not job related.

The claimant did not put forward any claim this was job related.

The disability form shows he was seen by the doctor on 2/25/91. The informant does not know how long he had this condition with the hand. The informant does not know if he had any lost time due to this condition before the operation.

From 1/8/92 through 3/30/92, he was on disability due to the surgery. He had no other prior permanent conditions as per the assured's records.

M. S. Staruch

38846663-044

Giladi

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On 6/13/93, he had another accident in which he injured his back. He has been out since 8/12/93 due to this injury. He did not return back to work. The informant has no medical information regarding the treatment he received for the injury to the back on 6/13/93.

He did not submit any disability form after the injury on 6/30/93. The informant does not know if he is collecting any SSI. He did not apply for Unemployment. He is not being paid.

He does not wear eyeglasses, contact lenses or a hearing device.

He is not related to any principal official of the facility.

Vital Points:

1. The claimant was out for surgery of the left hand from 12/12/91 through 12/17/91. He was on sick leave during this period. The informant did not receive any medical notes regarding this. He was operated on 12/12/91. The details are not available.

2. From 1/8/92 through 3/30/92, the claimant was on disability due to this surgery. The disability form indicates that the condition was compression of the left medial nerve at the wrist. The doctor has indicated that it is not job related. The claimant has never put forward any claim that it is job related.

M. S. Allen

After disability, he returned back to work with his hand in a cast on 12/17/91. The next day on 12/18/91, he had the accident.


Due to this accident in which he injured his left hand, he lost only two days and he was on sick leave for these days.

3. At the same time, the informant says that the disability from 1/8/92 through 3/30/92 was due to the surgery. It could be presumed that the surgery was for the compression of the left medial nerve at the wrist. Probably, the accident on 12/18/91 might have aggravated the condition due to re-injury.

4. He had another accident. This had nothing to do with the hand. It was on 6/30/93 and he injured his back. He was out since then.

Note attached: C-142, C-201.A, copy of disability form, and C-99.

5/6/94



M.S. Alexander
Sr. Compensation Claims Investigator